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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

Item 9 Film G288 6/7/61 iwk

5657

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05645

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>		c. LENGTH OF STAY IN 1b <u>4 months</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford County Alms House</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pylesville</u>	
3. NAME OF DECEASED (Type or print) First <u>Hobart</u> Middle <u>Bay</u> Last <u>Bay</u>		4. DATE OF DEATH Month <u>May</u> Day <u>29</u> Year <u>19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 21, 1896</u>
9. AGE (In years last birthday) <u>65</u> <u>64</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Employee</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Railroad Employee</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>United States</u>	
13. FATHER'S NAME <u>Oliver Alexander Bay</u>		14. MOTHER'S MAIDEN NAME <u>Fannie Caloway Smithson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-12-5238</u>	
17. INFORMANT <u>Mrs. Ralph Manifold, Stewartstown, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary sclerosis</u> DUE TO (c) <u>Chr. Cardio-vascular Disease</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>			
INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>0. 11.</u> p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Feb. 2, 19 61</u> , to <u>May, 29, 19 61</u> , that I last saw the deceased alive on <u>May 25, 19 61</u> , and that death occurred at <u>12:30PM</u> , from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. <u>Forest Hill, Md.</u> <u>May 29, 1961</u>			
PHYSICIAN'S NAME (Type) <u>Willard P. Hudson M.D.</u> <u>Forest Hill, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 1, 1961</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		22d. LOCATION (City, town, or county) (State) <u>Rocks, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Harkins</u> ADDRESS <u>Delta, Penna.</u>		24a. REC'D BY REGISTRAR DATE <u>JUN 5 '61</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

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VR A15 (4)
ISM 9/60

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
CERTIFICATE OF DEATH																	
5658																	
05646																	
1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u> c. LENGTH OF STAY IN 1b <u>2 hrs. 24 min</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD MEMORIAL HOSPITAL</u>						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u> d. STREET ADDRESS <u>102 SENECA ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)		First <u>WILLIAM</u>		Middle <u>CLAUDE</u>		Last <u>BOWMAN</u>		4. DATE OF DEATH Month <u>MAY</u> Day <u>22</u> Year <u>1961</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MAY 22, 1961</u>		9. AGE (In years last birthday) yrs. <u>21</u> Months <u>24</u> Days <u>24</u> Hours <u>24</u> Min. <u>24</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)							
10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?								
13. FATHER'S NAME <u>BILL E. BOWMAN</u>						14. MOTHER'S MAIDEN NAME <u>NATALIE LEISHMAN</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>						16. SOCIAL SECURITY NO. <u>no</u>						17. INFORMANT <u>Hosp & friends</u> Address <u>Havre de Grace Md</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral anoxia</u> 7635 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Pneumonia subacute</u> (c), stating the underlying cause last. <u>Prematurity</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> INTERVAL BETWEEN ONSET AND DEATH <u>1 dg</u> <u>1 dg</u>																	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
MEDICAL CERTIFICATION																	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from....., 19....., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occurred at.....19....., from the causes and on the date stated above.																	
22a. SIGNATURE <u>Irvin L. Wachsmann</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED <u>5/24/61</u>								
22c. PHYSICIAN'S NAME (Type) <u>IRVIN L. WACHSMANN</u>						22d. ADDRESS <u>407 S. UNION AVE. HAVRE DE GRACE MD.</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE THEREOF <u>5/24/61</u>			23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>			23d. LOCATION (City, town or county) (State) <u>Havre de Grace Md.</u>								
24. FUNERAL DIRECTOR'S SIGNATURE <u>Remington, Jr., Havre de Grace Md.</u>						25a. REC'D BY REGISTRAR <u>MAY 29 '61</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>								

11-27-21

11-27-21

11

Harold W. Brown
George W. Brown
William W. Brown
M. W. Brown

Bill E. Brown
No. 1
Central
Brown

George W. Brown
William W. Brown
M. W. Brown
Bill E. Brown

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 05647

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Abingdon</u>	
c. LENGTH OF STAY IN 1b <u>32m</u>		d. STREET ADDRESS <u>Bush Road</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Bush Road</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas</u> First <u>Braxton</u> Middle <u>Braxton</u> Last <u>Braxton</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 17, 1861</u>
9. AGE (In years last birthday) <u>100</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Owner</u>	
11. BIRTHPLACE (State or foreign country) <u>USA Va</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Elizabeth Harris</u>		Address <u>Baltimore, Md.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c) DUE TO (c) stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>Gerald E Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Gerald E Palmer</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>5-3-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May, 7, 1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>John Wesley</u>	22d. LOCATION (City, town, or county) (State) <u>Abingdon, Harford, Maryland.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard K. MeComas & Son</u>		ADDRESS <u>Abingdon, Maryland.</u>	
24a. REC'D BY REGISTRAR <u>MAY 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1935

(M)

(F)

3-10-35, No. 1

City of Baltimore

John

65

RESIDENT

Causes of death: 1. Myocardial infarction 2. Coronary atherosclerosis 3. Hypertension 4. Diabetes mellitus 5. Chronic bronchitis 6. Emphysema 7. Arteriosclerosis 8. Atherosclerosis 9. Sclerosis 10. Degeneration 11. Inflammation 12. Infection 13. Trauma 14. Poisoning 15. Other

Signature of Medical Examiner

Witness: J. Edgar Hoover, Director, Federal Bureau of Investigation

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5660 CERTIFICATE OF DEATH 115648											
1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>						c. LENGTH OF STAY in 1b <u>20 days</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial</u>						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>					
4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>61</u>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Charles J. Callahan</u>		First <u>Charles</u> Middle <u>J.</u> Last <u>Callahan</u>		4. DATE OF DEATH Month <u>5</u> Day <u>29</u> Year <u>61</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Charles J. Callahan</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Bodani</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Joshua Leshu</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Prostatic Gland</u> 142.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1960</u> to <u>May 1961</u> , that (I) (we) last saw the deceased alive on <u>5-29-1961</u> and that death occurred at <u>5-29-61</u> P.M. from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward J. Simon</u> M.D.						22b. DATE SIGNED <u>5-29-61</u>					
22c. PHYSICIAN'S NAME (Type) <u>E. J. SIMON</u>						22d. ADDRESS <u>HAURE DE GRACE, MD</u>					
23a. (BURIAL) CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>June 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. John Catholic</u>		23d. LOCATION (City, town or county) (State) <u>Long Green Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Runger R. Haure de Grace, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>JUN 5 '61</u>	
								25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thoma</u>			

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Harvard University, to pay
Harvard Memorial

Charles W. Colburn

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Wrote to

Harvard

to

Robert

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Charles W. Colburn
Harvard University

Harvard University
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

05649

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>70 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford, Md.</u> d. STREET ADDRESS <u>623 Ontario</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Arthur Chapman Caponic</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>5/29/61</u> <u>19</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 3, 1890</u> yrs. Months Days
9. AGE (In years last birthday) <u>70</u>		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cities Post Office Supt.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Carsons Ann Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		13. FATHER'S NAME <u>Chapman Caponic</u>	
14. MOTHER'S MAIDEN NAME <u>Mary C. Flarity</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Laura Caponic</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Diabetes Mellitus</u> (b) (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>5-7</u> , 19 <u>54</u> to <u>3-29</u> , 19 <u>61</u> that (I) (we) last saw the deceased alive on <u>3-29</u> , 19 <u>61</u> , and that death occurred at <u>11</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u> M.D.		22b. ADDRESS	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>6/2/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>	23d. LOCATION (City, town or county) (State) <u>Harford Chase, Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Harford Chase, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 5 '61</u>	
		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5662

CERTIFICATE OF DEATH

Reg. Dist. No.

05650

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hand Chase</u>				c. LENGTH OF STAY IN 1b <u>3 yrs</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hand Chase</u>				d. STREET ADDRESS <u>140 St. John</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Hiram U. Case</u> First Middle Last				4. DATE OF DEATH <u>5/12/61</u> Month Day Year			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/12/1887</u>		9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Advertising</u>		11. BIRTHPLACE (State or foreign country) <u>Hand Chase, Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Nelson B Case</u>				14. MOTHER'S MAIDEN NAME <u>Mary E. Esley</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>W. James B.</u>		18. ADDRESS <u>Hand Chase, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1/6</u> , 19 <u>59</u> , to <u>6-12</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>4-17</u> , 19 <u>61</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				22a. REC'D BY REGISTRAR DATE <u>MAY 18 '61</u>			
PHYSICIAN'S NAME (Type) <u>Z. J. H. H. H.</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/14/61</u>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <u>Hand Chase, Md</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Hand Chase, Md</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 18 '61</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1965

NAME OF DECEASED		DATE OF BIRTH	
JAMES EARL RAY		5-1-28	
PLACE OF BIRTH		DATE OF DEATH	
MOBILE, ALABAMA		4-6-68	
AGE		40	
SEX		MALE	
RACE		WHITE	
MARRIED		YES	
SINGLE		NO	
EDUCATION		HIGH SCHOOL	
OCCUPATION		CONGRESSMAN	
CAUSE OF DEATH		HEART DISEASE	
MANNER OF DEATH		NATURAL	
PLACE OF DEATH		HOTEL MONTELEONE, NEW ORLEANS, LA	
DATE OF INTERMENT		4-8-68	
PLACE OF INTERMENT		CATHOLIC CHURCH, NEW ORLEANS, LA	
SIGNATURE OF DECEASED		SIGNATURE OF PHYSICIAN	
JAMES EARL RAY		[Signature]	
DATE		DATE	
4-6-68		4-6-68	

THIS CERTIFICATE IS VALID FOR THE STATE OF MARYLAND ONLY. IT IS NOT VALID FOR OTHER STATES OR COUNTRIES. IT IS THE DUTY OF THE PHYSICIAN TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE CAUSE OF DEATH. IT IS THE DUTY OF THE REGISTRAR TO SIGN THIS CERTIFICATE AND TO FURNISH A TRUE AND CORRECT STATEMENT OF THE PLACE OF DEATH AND INTERMENT.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

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BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5663

05651

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street</u>		c. LENGTH OF STAY IN 1b <u>30 yrs.</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Street</u>		d. STREET ADDRESS <u>Route #2 Box 300</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Route #2 Box 300</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>H.</u> Last <u>Cecis, Sr.</u>		4. DATE OF DEATH Month <u>5</u> Day <u>1</u> Year <u>1961</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Oct. 1, 1896</u>		9. AGE (In years last birthday) <u>64</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Army Chemical Center</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Harford County</u>		12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u>	
13. FATHER'S NAME <u>Benjamin Cecis</u>		14. MOTHER'S M maiden NAME <u>Hannah Morgan</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes WWI</u>		16. SOCIAL SECURITY NO. <u>220-01-5788</u>		17. INFORMANT <u>Mrs. Mary E. Cecis, Street, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> <u>603X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular disease</u> DUE TO (c) <u>Renal Insufficiency</u>							INTERVAL BETWEEN ONSET AND DEATH <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>C.V.A.</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>11/17</u> , 19 <u>60</u> to <u>5/1</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>4/28</u> , 19 <u>61</u> , and that death occurred at <u>7:30 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>George T. Stansbury</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5/2/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u>				22d. ADDRESS <u>569 Revolution St. Harford, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5-6-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Oakwood Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Darlington, Harford Co. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Elmer T. Bullock, Harford, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>MAY 3 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

5563

(M)

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

5664

05652

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVREDE GRACE				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVREDE GRACE 24			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 324 Superior, ST				d. STREET ADDRESS 324 SUPERIOR, ST. 1			
3. NAME OF DECEASED (Type or print) First Middle Last SAMUEL GOLDSMITH CURRY				4. DATE OF DEATH Month Day Year MAY 12 1961			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 29 1892	9. AGE (In years last birthday) 68	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) TELEPHONE REPAIRMAN		10b. KIND OF BUSINESS OR INDUSTRY A.P.S. RETIRED		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN SAMUEL CURRY				14. MOTHER'S MAIDEN NAME MARGARET LEE WRIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) —		16. SOCIAL SECURITY NO. 213-05-7273		17. INFORMANT Mrs. Lottie L. Curry, 324 Superior St. Havre de Grace, MD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Myocardial Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Occlusion DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH 24 hours
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 5-12 1961 , to 5-12 1961 , that (I) (we) lost the deceased on 5-12 1961 , and that death occurred at 7:30 PM , from the causes and on the date stated above.							
22a. SIGNATURE [Signature]				22b. DATE SIGNED 5-13-61			
22c. PHYSICIAN'S NAME (Type) DR. C. HIRSCH				22d. ADDRESS 421 CONGRESS AVE. HAVRE DE GRACE			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF MAY 15 1961	23c. NAME OF CEMETERY OR CREMATORY ROCK RUN CEM.	23d. LOCATION (City, town, or county) (State) HARFORD MD				
24. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				25a. REC'D BY REGISTRAR DATE 17 '61		25b. REGISTRAR'S SIGNATURE [Signature]	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5665

05653

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Hartford Memorial Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> d. STREET ADDRESS <u>R.D. 1 XXXXXXXXXX</u> e. RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Mary. Augusta Deckman</u> First Middle Last		4. DATE OF DEATH <u>5-25-1961</u> Month Day Year	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Nov. 24, 1878</u> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. AGE (In years last birthday) <u>82</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife, Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>John F. Finkernagel</u>		14. MOTHER'S MAIDEN NAME <u>Amelia H. Oales</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Frances C. Preston, Aberdeen, Md.</u> Address <u>627 Jennifer Lane</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolus</u> (b) <u>Rt. Supracondylar Fracture</u> (c) <u>Generalized Osteoporosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 hrs.</u> <u>5 days</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Senile Dementia due to Cerebral Arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/20</u> , 19 <u>61</u> , to <u>5/25</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>5/25</u> , 19 <u>61</u> , and that death occurred at <u>12:30</u> P.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>M. H. Sadowsky</u> M.D.		22b. DATE <u>May 25, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. H. SADOWSKY</u>		22d. ADDRESS <u>504 Lewis St. Harre-de-Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/27/61</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Havre de Grace, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Tarring</u>		25. REC'D BY REGISTRAR <u>JUN 5 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>		25c. ADDRESS <u>Aberdeen, Md.</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

1885

1885

Nov. 24, 1878

U.S.A.

James H. Housewife, Rome

John E. Winkelman

Amelia H. Oakes

None

No

Frances C. Preston, Aberdeen, Md.

[Faint, mostly illegible handwritten text, possibly a letter or record entry.]

Nov 25, 1885

Angel Hill Cemetery
Garrison Funeral Home
Aberdeen, Md.
Have no space, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5666

CERTIFICATE OF DEATH

05654

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> c. LENGTH OF STAY IN 1b <u>X</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Box 31 - Rural # 2</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u> d. STREET ADDRESS <u>Box 31 - Rural # 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Martin Gregory Jonathan</u>		4. DATE OF DEATH Month Day Year <u>5 11 1961</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6/10/1896</u>
9. AGE (in years last birthday) <u>64</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Civil Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Govt. etc.</u>	11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Bernard Jonathan</u>	
14. MOTHER'S MAIDEN NAME <u>Eunice Use</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> War <u>I</u>	
16. SOCIAL SECURITY NO. <u>214-14-0747</u>		17. INFORMANT <u>Gertrude K. Jonathan - Aberdeen</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebro-Vascular Accident</u> 331X Conditions, if any, which gave rise to immediate cause (b) <u>Hypertension</u> (c) <u>1956</u>		INTERVAL BETWEEN ONSET AND DEATH <u>One hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>March 1958</u> to <u>May 1961</u> , that (I) (we) last saw the deceased alive on <u>May 7 1961</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Andre Weiss</u> M.D.		22b. DATE SIGNED <u>May 12, 1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>ANDRE WEISS M.D.</u>		22d. ADDRESS <u>114 N. Bel Air Av. Aberdeen</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 15, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harford Memorial Gardens, RD. Havre de Grace</u>		23d. LOCATION (City, town or county) (State) <u>Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barrington - Aberdeen, Md.</u>		25. REC'D BY REGISTRAR <u>MAY 16 1961</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		25c. REGISTRAR'S NAME <u>Md.</u>	



1901
May 15, 1901
Hartford Memorial Hospital, Hartford, Conn.
To the Trustees of the Hartford Memorial Hospital
Dear Sirs:
I have the honor to acknowledge the receipt of your letter of the 14th inst. in relation to the above matter.
I am sorry to hear that you are unable to secure the desired result.
I am, Sir, very respectfully,
Yours truly,
J. H. [Name]
[Address]

1
FOR STATE
HEALTH DEPT.

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5667 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05655

1. PLACE OF DEATH a. COUNTY <i>Hartford</i>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Belt Air</i>		c. LENGTH OF STAY IN 1b		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>md</i>		b. COUNTY <i>Hartford</i>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Belt Air</i>		d. STREET ADDRESS <i>Johnsons Mill Road</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Izetta Rose</i>		First <i>Izetta</i>		Middle <i>Rose</i>		Last <i>Dowell</i>		4. DATE OF DEATH Month <i>May</i> Day <i>22</i> Year <i>1961</i>		5. SEX <i>F</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>June 6, 1907</i>		9. AGE (In years last birthday) <i>54</i>		IF UNDER 1 YEAR Months <i>14</i> Days <i>16</i>		IF UNDER 24 HRS. Hours <i>14</i> Min. <i>32</i>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housework at home</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Allegheny Co., Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Emory Burchew</i>		14. MOTHER'S MAIDEN NAME <i>Haral Hill</i>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mack Dowell</i>		Address <i>Belt Air, Md</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>Bel air, md</i> (c) <i>Rt 10</i> DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)										21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>May 25, 1961</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Sharta M.C.</i>		22d. LOCATION (City, town, or country) <i>M.C.</i>		23. FUNERAL DIRECTOR <i>H.S. Bailey</i>		Address <i>Wilmington Md</i>		24a. REC'D BY REGISTRAR <i>MAY 25 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>	

MEDICAL CERTIFICATION

2

I

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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BP

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15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5668

05656

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Hartford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Haure de Grace</u>	
c. LENGTH OF STAY IN lb <u>2 days</u>		d. STREET ADDRESS <u>428 S. Union Ave</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Martin</u> First <u>P</u> Middle <u>Foley</u> Last	4. DATE OF DEATH <u>5</u> Month <u>1</u> Day <u>19</u> Year <u>61</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/13/1904</u>
9. AGE (In years last birthday) <u>56</u> yrs.		IF UNDER 1 YEAR Months <u>5</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unemployed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Program Review</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Md-Hartford Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Martin P. Foley</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Koendress</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Peritonitis</u> DUE TO (b) <u>Chronic Paralytic ileus</u> DUE TO (c) <u>Dehydration</u> Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Prolonged Diuretic Administration</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11 AM May 1, 1961</u> to <u>10 PM May 1, 1961</u> that (I) <u>last</u> saw the deceased alive on <u>May 1, 1961</u> , and that death occurred at <u>10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W H Sadowsky</u> M.D.		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <u>May 2, 1961</u>
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>504 Lewis St, Haure de Grace</u>	
23a. (BURIAL, CREMATION, REMOVAL) (Specify)	23b. DATE THEREOF <u>5/4/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Ann</u>	23d. LOCATION (City, town or county) (State) <u>Haure de Grace, Md</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony J. Smith</u>		25a. REC'D BY REGISTRAR <u>MAY 8 '61</u>	25b. REGISTRAR'S SIGNATURE <u>Anthony J. Smith</u>



12/11/1941 10:10 AM

TO HOST: R ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5668
CERTIFICATE OF DEATH

45657

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Maryland b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVER DE GRACE		c. LENGTH OF STAY IN 1b 2 DAYS	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD Memorial Hosp.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Darlington	
3. NAME OF DECEASED (Type or print) Baby Girl		d. STREET ADDRESS 1	
4. DATE OF DEATH Month MAY Day 8 Year 1961		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-6-61
9. AGE (In years last birthday) yrs. 2		IF UNDER 1 YEAR Months 2 Days 2 Hours 2 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN		10b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown		14. MOTHER'S MAIDEN NAME Josephine Sutton	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT Josephine Sutton Darlington		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coarctation, ductal of aorta 754-J DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Patent ductus arteriosus DUE TO (c) CONGENITAL ANOMALY		INTERVAL BETWEEN ONSET AND DEATH at birth	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 6 , 19 61 to MAY 8 , 19 61 , that (I) (see) last saw the deceased alive on MAY 8 , 19 61 , and that death occurred at 5AM , from the causes and on the date stated above.			
22a. SIGNATURE Frank Wolbert M.D.		22b. DATE SIGNED MAY 9, 1961	
22c. PHYSICIAN'S NAME (Type) FRANK WOLBERT M.D.		22d. ADDRESS HAVER DE GRACE MARYLAND	
23a. BURIAL (CREMATION) REMOVAL (Specify) cremation		23b. DATE THEREOF May 8, 1961	
23c. NAME OF CEMETERY OR CREMATORY Harford Memorial Hosp		23d. LOCATION (City, town or county) (State) Haver de Grace, Md	
24. FUNERAL DIRECTOR'S SIGNATURE Harry R. Tully administrator		25a. REC'D BY REGISTRAR MAY 31 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. House		DATE	

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(M)

2000

Patent Office
Washington, D.C.

Very respectfully,
Your obedient servant,
[Signature]

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: *John J. Brown*
AGE: *45*
SEX: *M*
RACE: *W*
DATE OF DEATH: *10/15/1911*
PLACE OF DEATH: *Home*
CAUSE OF DEATH: *Myocardial Infarction*
MANNER OF DEATH: *Natural*
SIGNATURE OF EXAMINER: *J. J. Brown*
OFFICE OF THE MEDICAL EXAMINER: *New York City*

1. Name of Deceased: *John J. Brown*
2. Age: *45*
3. Sex: *M*
4. Race: *W*
5. Date of Death: *10/15/1911*
6. Place of Death: *Home*
7. Cause of Death: *Myocardial Infarction*
8. Manner of Death: *Natural*
9. Signature of Examiner: *J. J. Brown*
10. Office of the Medical Examiner: *New York City*

11. Name of Physician: *J. J. Brown*
12. Address: *1234 Broadway*
13. City: *New York*
14. State: *New York*
15. Date of Examination: *10/15/1911*
16. Time of Examination: *10:00 AM*
17. Signature of Physician: *J. J. Brown*
18. Office of the Physician: *New York City*

19. Name of Coroner: *J. J. Brown*
20. Address: *1234 Broadway*
21. City: *New York*
22. State: *New York*
23. Date of Examination: *10/15/1911*
24. Time of Examination: *10:00 AM*
25. Signature of Coroner: *J. J. Brown*
26. Office of the Coroner: *New York City*

27. Name of Registrar: *J. J. Brown*
28. Address: *1234 Broadway*
29. City: *New York*
30. State: *New York*
31. Date of Examination: *10/15/1911*
32. Time of Examination: *10:00 AM*
33. Signature of Registrar: *J. J. Brown*
34. Office of the Registrar: *New York City*

35. Name of Medical Examiner: *J. J. Brown*
36. Address: *1234 Broadway*
37. City: *New York*
38. State: *New York*
39. Date of Examination: *10/15/1911*
40. Time of Examination: *10:00 AM*
41. Signature of Medical Examiner: *J. J. Brown*
42. Office of the Medical Examiner: *New York City*

M

1

10/15/1911

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5671

CERTIFICATE OF DEATH

Reg. Dist. No.

45654

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural--Darlington		c. LENGTH OF STAY IN 1b 15 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural-- Darlington	
3. NAME OF DECEASED (Type or print) First Middle Last Otis Henry Hunt Hunt		4. DATE OF DEATH Month Day Year May 4, 1961 19	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 5, 1897
9. AGE (In years last birthday) yrs. 63		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Aberdeen P.G.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) New Hampshire		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Henry Otis Hunt		14. MOTHER'S MAIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW I		16. SOCIAL SECURITY NO. 003-01-064	
17. INFORMANT Mrs Gale Hunt		Address Darlington, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 414X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic endocarditis and myocarditis (Chronic) DUE TO (c) ??		INTERVAL BETWEEN ONSET AND DEATH 20 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 2, 1950 , to May 1961 , 19____, that I last saw the deceased alive on May 6, 1960 , and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Willard P. Hudson M.D. Forest Hill, Md. 5/5/61			
ACTUAL SIGNATURE Willard P. Hudson			
PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL CREMATION, REMOVAL (Specify) May 8, 1961		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY Bd-air Memorial at Harford Co., Md.		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE H. S. Bailey		ADDRESS Darlington, Md.	
24a. REC'D BY REGISTRAR DATE MAY 10 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Kneass	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5672

CERTIFICATE OF DEATH

Reg. Dist. No. 05660

1. PLACE OF DEATH a. COUNTY <u>Harford Maryland</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ham de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ham de Grace</u> 24	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <u>217 N. Union Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Bennett Aquila Keen</u>		4. DATE OF DEATH <u>5/21/61</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/18/1863</u> 99 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Waterman</u>	
11. BIRTHPLACE (State or foreign country) <u>Arkansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Aquila Keen</u>		14. MOTHER'S MAIDEN NAME <u>Charlotte Johnson Mary Tignor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>Unknown</u>		16. SOCIAL SECURITY NO. <u>Unknown</u>	
17. INFORMANT <u>Oden Keen</u> <u>217 N. Union Ave.</u>		<u>Ham de Grace, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>422.2</u> DUE TO <u>Cardiac Insufficiency</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>AGE</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE _____ M.D.			
PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <u>5/23/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Ham de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William S. Thoms</u> ADDRESS <u>Ham de Grace, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 25 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>William S. Thoms</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5673

CERTIFICATE OF DEATH

Reg. Dist. No. 05661

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Street				c. LENGTH OF STAY IN 1b 76 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#2				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle HENRY Last KOHLBUS				4. DATE OF DEATH Month ay Day 23 Year 19 61			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 3, 1885	
9. AGE (In years last birthday) 76 yrs.		10. IF UNDER 1 YEAR Months ay Days 23 Hours 19 Min.		11. BIRTHPLACE (State or foreign country) Baltimore, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME William H. Kohlbus				14. MOTHER'S MAIDEN NAME Elizabeth Nichols			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 218-07-0294		17. INFORMANT Mrs. Paul Iddings, Street, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic myocarditis 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that I attended the deceased from March 1, 1961 , to May 22, 1961 , that I last saw the deceased alive on May 22, 1961 , and that death occurred at 4 A. M. from the causes and on the date stated above. ACTUAL SIGNATURE Edward W. Hyson M.D. ADDRESS (Street, city or town, state) Fawn Grove, Penna. DATE SIGNED 5/24/61 PHYSICIAN'S NAME (Type) Edward W. Hyson 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 22b. DATE THEREOF May 25, 1961 22c. NAME OF CEMETERY OR CREMATORY Emory 22d. LOCATION (City, town, or county) (State) Street, Md. 23. FUNERAL DIRECTOR'S SIGNATURE John H. Haskins ADDRESS elta, enna. 24a. REC'D BY REGISTRAR MAY 26 '61 24b. REGISTRAR'S SIGNATURE Criss S. Hays							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned to the hospital or attending physician.
TO FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARIANO STATE DEPARTMENT OF HEALTH - BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5674

CERTIFICATE OF DEATH

Reg. Dist. No. 05662

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>St. Mt. Royal Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Claude Krauss</u>		4. DATE OF DEATH <u>May 8th 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/14/1901</u>
9. AGE (In years last birthday) <u>60</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Barber, self-employed</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Krauss</u>		14. MOTHER'S MAIDEN NAME <u>Marjorie Suder</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>214-16-9442</u>	
17. INFORMANT <u>Uelma Palmer Krauss</u> Address <u>St. Mt. Royal Ave Aberdeen Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 Ventricular Fibrillation</u> DUE TO (b) <u>Coronary Occlusion</u> DUE TO (c) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>Diabetes Mellitus</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Terminal</u> <u>5 minutes</u> <u>5 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1953</u> , 19 <u>53</u> to <u>5-8</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>1-15-1961</u> , and that death occurred at <u>1:55 A.M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Peter P. Rodman, M.D.</u>		ADDRESS (Street, city or town, state) <u>8 Law St. Aberdeen, Md.</u> DATE SIGNED <u>5-8-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Babers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Aberdeen, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Barring</u> ADDRESS <u>Aberdeen, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAY 12 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1904

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

CAUSE OF DEATH

PLACE OF DEATH

DATE OF BURIAL

PLACE OF BURIAL

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CHURCH

NAME OF CEMETERY

NAME OF INTERVIEWER

NAME OF REGISTRAR

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

NAME OF JURY

NAME OF JUDGE

NAME OF SHERIFF

NAME OF CONSTABLE

NAME OF DEPUTY

NAME OF CLERK

NAME OF ASSISTANT

NAME OF OFFICIAL

1
FOR STATE
HEALTH DEPT. M

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5675 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05664

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) e. STATE <u>N.C.</u> b. COUNTY <u>Greene</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hartford</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Statesville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Hartford Memorial Hospital</u>		d. STREET ADDRESS <u>1218 Broad Street</u>	
3. NAME OF DECEASED (Type or print) <u>David Ivey Lanier</u>		4. DATE OF DEATH <u>May 18 1961</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 24, 1912</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Truck driver</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Trucking</u>	9. AGE (In years last birthday) <u>48</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Greene Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>M. M. Lanier</u>		14. MOTHER'S MAIDEN NAME <u>Dora Hawthorn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Skull</u> 9/10-9 DUE TO Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Fractures pelvis + femur</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>2 logs fell on him</u>	
20c. TIME OF INJURY Month, Day, Year <u>5</u> Hour <u>5-12</u> p.m. <u>19 61</u>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work Not White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rising Sun</u>
20f. (City or town) <u>Rising Sun</u> (County) <u>Cecil</u> (State) <u>MD</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Belt Air, Md</u>
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 20, 1961</u>
22c. NAME OF CEMETERY OR CREMATORY <u>Abilene Ch. of Christ Cem.</u>		22d. LOCATION (City, town, or country) <u>Greene Co. N.C.</u>
23. FUNERAL DIRECTOR <u>Pennington & Son, Harde de Grace Md.</u>		24a. REC'D BY REGISTRAR <u>May 22 '61</u>
		24b. REGISTRAR'S SIGNATURE <u>Charles S. Thrash</u>

THE STATE
DEPT. OF HEALTH

5773

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH
STATE OF ALABAMA
BIRMINGHAM, ALABAMA

NAME OF DECEASED *John A. Smith*
AGE *45* SEX *M*
RESIDENCE *1234 Main St. Birmingham, Ala.*
DATE OF DEATH *Jan 15, 1925*
PLACE OF DEATH *Home*
CAUSE OF DEATH *Myocardial Infarction*
MANNER OF DEATH *Natural*
SIGNATURE OF EXAMINER *Dr. J. H. Brown*
DATE *Jan 16, 1925*

EDUCATION *High School Graduate*
OCCUPATION *Engineer*
MARRIAGE *Married*
SOURCES OF INCOME *Salary*
HISTORY OF PRESENT ILLNESS *Onset of chest pain Jan 14, 1925, at 10:00 AM. Pain increased and was accompanied by sweating and nausea. Death occurred at 11:30 AM.*
PREVIOUS ILLNESSES *None*
SMOKING HABIT *Yes*
ALCOHOLIC HABIT *No*
SIGNATURE OF EXAMINER *Dr. J. H. Brown*
DATE *Jan 16, 1925*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8 & 9 Film G288 5/29/61 iwk

5676

CERTIFICATE OF DEATH

Reg. Dist. No. 05667

<p>1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>40 yrs.</u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION _____</p>				<p>2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u> d. STREET ADDRESS <u>701 Erie</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p>					
<p>3. NAME OF DECEASED (Type or print) <u>Bernadina L. Leonard</u> First Middle Last</p>				<p>4. DATE OF DEATH <u>5/17/61</u> Month Day Year</p>					
<p>5. SEX <u>Female</u></p>		<p>6. COLOR OR RACE <u>White</u></p>		<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <u>1884</u> <u>9/38/1884</u></p>		<p>9. AGE (In years last birthday) <u>76</u> IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.</p>	
<p>10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Wife</u></p>				<p>10b. KIND OF BUSINESS OR INDUSTRY <u>none</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Italy</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>Italy</u></p>	
<p>13. FATHER'S NAME <u>Joseph Levi</u></p>				<p>14. MOTHER'S MAIDEN NAME <u>Unknown</u></p>					
<p>15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u></p>				<p>16. SOCIAL SECURITY NO. <u>Unknown</u></p>		<p>17. INFORMANT <u>Maria Lay Revolution</u> Address <u>Harford</u></p>			
<p>18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ADENOCARCINOMA OF BLADDER</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)</p>								<p>INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u></p>	
<p>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</p>								<p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/></p>	
<p>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</p>				<p>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</p>					
<p>20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u></p>				<p>20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/></p>		<p>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</p>		<p>20f. (City or town) (County) (State)</p>	
<p>21. I certify that I attended the deceased from <u>December, 1960</u>, to <u>5-17</u>, 19<u>61</u>, that I last saw the deceased alive on <u>5-17</u>, 19<u>61</u>, and that death occurred at <u>2:15 A.M.</u>, from the causes and on the date stated above.</p>									
<p>ACTUAL SIGNATURE <u>Gunter D. Hirsch</u> M.D. <u>421 CONGRESS AV.</u> ADDRESS (Street, city or town, state) DATE SIGNED <u>5-18-61</u></p>				<p>PHYSICIAN'S NAME (Type) <u>GUNTHER D. HIRSCH</u> <u>HARVRE DE GRACE, MD.</u></p>					
<p>22a. BURIAL, CREMATION, REMOVAL (Specify)</p>		<p>22b. DATE THEREOF <u>5/20/61</u></p>		<p>22c. NAME OF CEMETERY OR CREMATORY <u>Not Enin</u></p>		<p>22d. LOCATION (City, town, or county) (State) <u>Harford</u></p>			
<p>23. FUNERAL DIRECTOR'S SIGNATURE <u>Harford</u> ADDRESS <u>Harford</u></p>				<p>24a. REC'D BY REGISTRAR <u>MAY 19 61</u></p>		<p>24b. REGISTRAR'S SIGNATURE <u>Charles E. Hirsch</u></p>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1921

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH		9. PLACE OF DEATH		10. TIME OF DEATH	
11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF CORONER		13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF CLERK		18. SIGNATURE OF JURY		19. SIGNATURE OF JUDGE		20. SIGNATURE OF SHERIFF	
21. SIGNATURE OF DISTRICT ATTORNEY		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF TOWNSHIP CLERK		24. SIGNATURE OF VILLAGE CLERK		25. SIGNATURE OF CITY CLERK	
26. SIGNATURE OF STATE CLERK		27. SIGNATURE OF FEDERAL CLERK		28. SIGNATURE OF MARINE CLERK		29. SIGNATURE OF NAVY CLERK		30. SIGNATURE OF AIR FORCE CLERK	
31. SIGNATURE OF ARMY CLERK		32. SIGNATURE OF COAST GUARD CLERK		33. SIGNATURE OF CUSTOMS CLERK		34. SIGNATURE OF EXCISE CLERK		35. SIGNATURE OF POST OFFICE CLERK	
36. SIGNATURE OF TELEGRAPH CLERK		37. SIGNATURE OF RAILROAD CLERK		38. SIGNATURE OF STEAMSHIP CLERK		39. SIGNATURE OF AIRCRAFT CLERK		40. SIGNATURE OF MOTOR VEHICLE CLERK	
41. SIGNATURE OF FISH AND GAME CLERK		42. SIGNATURE OF FOREST AND WILDLIFE CLERK		43. SIGNATURE OF MINES AND METALS CLERK		44. SIGNATURE OF OIL AND GAS CLERK		45. SIGNATURE OF COAL AND LUMBER CLERK	
46. SIGNATURE OF AGRICULTURE CLERK		47. SIGNATURE OF FISHERY CLERK		48. SIGNATURE OF HUNTING AND TRAPPING CLERK		49. SIGNATURE OF FISHING AND BOATING CLERK		50. SIGNATURE OF CAMPING AND TRAVEL CLERK	
51. SIGNATURE OF TOURISM CLERK		52. SIGNATURE OF RECREATION CLERK		53. SIGNATURE OF EDUCATION CLERK		54. SIGNATURE OF CULTURE CLERK		55. SIGNATURE OF ARTS AND CRAFTS CLERK	
56. SIGNATURE OF SCIENCE CLERK		57. SIGNATURE OF TECHNOLOGY CLERK		58. SIGNATURE OF INVENTION CLERK		59. SIGNATURE OF DESIGN CLERK		60. SIGNATURE OF MANUFACTURING CLERK	
61. SIGNATURE OF CONSTRUCTION CLERK		62. SIGNATURE OF ARCHITECTURE CLERK		63. SIGNATURE OF ENGINEERING CLERK		64. SIGNATURE OF MECHANICAL CLERK		65. SIGNATURE OF ELECTRICAL CLERK	
66. SIGNATURE OF CHEMISTRY CLERK		67. SIGNATURE OF PHYSICS CLERK		68. SIGNATURE OF BIOLOGY CLERK		69. SIGNATURE OF MEDICINE CLERK		70. SIGNATURE OF DENTISTRY CLERK	
71. SIGNATURE OF VETERINARY CLERK		72. SIGNATURE OF AGRICULTURE CLERK		73. SIGNATURE OF FISHERY CLERK		74. SIGNATURE OF HUNTING AND TRAPPING CLERK		75. SIGNATURE OF FISHING AND BOATING CLERK	
76. SIGNATURE OF CAMPING AND TRAVEL CLERK		77. SIGNATURE OF TOURISM CLERK		78. SIGNATURE OF RECREATION CLERK		79. SIGNATURE OF EDUCATION CLERK		80. SIGNATURE OF CULTURE CLERK	
81. SIGNATURE OF ARTS AND CRAFTS CLERK		82. SIGNATURE OF SCIENCE CLERK		83. SIGNATURE OF TECHNOLOGY CLERK		84. SIGNATURE OF INVENTION CLERK		85. SIGNATURE OF DESIGN CLERK	
86. SIGNATURE OF MANUFACTURING CLERK		87. SIGNATURE OF CONSTRUCTION CLERK		88. SIGNATURE OF ARCHITECTURE CLERK		89. SIGNATURE OF ENGINEERING CLERK		90. SIGNATURE OF MECHANICAL CLERK	
91. SIGNATURE OF ELECTRICAL CLERK		92. SIGNATURE OF CHEMISTRY CLERK		93. SIGNATURE OF PHYSICS CLERK		94. SIGNATURE OF BIOLOGY CLERK		95. SIGNATURE OF MEDICINE CLERK	
96. SIGNATURE OF DENTISTRY CLERK		97. SIGNATURE OF VETERINARY CLERK		98. SIGNATURE OF AGRICULTURE CLERK		99. SIGNATURE OF FISHERY CLERK		100. SIGNATURE OF HUNTING AND TRAPPING CLERK	

1 FOR STATE HEALTH DEPT.

TO DEPARTMENTAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05665

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air Rd 2</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air, Fountain Green</u>			
c. LENGTH OF STAY IN lb <u>1 year</u>				d. STREET ADDRESS <u>RID 2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>her home Fountain Green</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Alma Virginia Lewis</u>				4. DATE OF DEATH <u>May 1 1961</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb 29, 1880</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			
11. BIRTHPLACE (State or foreign country) <u>Independence, Va</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
13. FATHER'S NAME <u>Joseph Smith deal</u>				14. MOTHER'S MAIDEN NAME <u>Emily Wilcox</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give war or dates of service)				16. SOCIAL SECURITY NO. <u>-</u>			
17. INFORMANT <u>Mrs. Min. Jesse, Bel Air RD 2 Bel Air</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic C disease</u> <u>422</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				INTERVAL BETWEEN ONSET AND DEATH <u>-</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, md</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-2-61</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/4/1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bellin Memorial Gardens</u>		22d. LOCATION (City, town, or country) (State) <u>Bel Air Md.</u>	
23. FUNERAL DIRECTOR <u>Charles E. Kury Jarrettsville Md.</u>				24a. REC'D BY REGISTRAR <u>MAY 4 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	

MEDICAL CERTIFICATION

STATE DEPARTMENT OF HEALTH
MEDICAL EXAMINER
(M)

1918
No. 1234
Name of Deceased
Age
Sex
Date of Death
Place of Death
Cause of Death
Disease
Injury
Occupation
Signature of Medical Examiner
Date of Examination

(I)

5678

CERTIFICATE OF DEATH

Reg. Dist. No. 5668

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Havre De Grace		c. LENGTH OF STAY IN 1b 1 Yr.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 642 N. Adams St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Frank Middle J. Last Lewis		4. DATE OF DEATH Month May Day 18 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 20, 1885
9. AGE (In years last birthday) 75 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Engineer. Rail Road		10b. KIND OF BUSINESS OR INDUSTRY Penna.	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John F. Lewis		14. MOTHER'S MAIDEN NAME Josephine Jamison	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) 1903-1907		16. SOCIAL SECURITY NO. NONE	
17. INFORMANT Ada P. Lewis, 642 N. Adams St. Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis 592X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arterio Sclerosis	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from May 17, 1961, to May 17, 1961, that I last saw the deceased alive on May 17, 1961, and that death occurred at 3:15 A.M. from the causes and on the date stated above.	
ACTUAL SIGNATURE Clarence I. Benson M.D.		DATE SIGNED 5/19/61	
PHYSICIAN'S NAME (Type) Clarence I. Benson. M.D.		22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	
22b. DATE THEREOF 5-21-1961		22c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery	
22d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural.		23. FUNERAL DIRECTOR'S SIGNATURE Leea Patterson & Son	
ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE MAY 23 '61	
24b. REGISTRAR'S SIGNATURE Arthur S. Hanna			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF OHIO

Return

For the year ending

1891

State of Ohio

John F. Lewis

John F. Lewis

John F. Lewis

John F. Lewis

Aug. 30, 1891

Aug. 30, 1891

John F. Lewis

John F. Lewis

John F. Lewis

John F. Lewis

John F. Lewis

John F. Lewis

John F. Lewis

John F. Lewis

John F. Lewis

TO HOSTEL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5678
CERTIFICATE OF DEATH

05668

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAURE de GRACE</u>	
c. LENGTH OF STAY IN 1b <u>7 hrs 35 min</u>		d. STREET ADDRESS <u>200 S. Stokes St</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Marguerite H. McComas</u>		4. DATE OF DEATH <u>May 2</u> 19 <u>61</u>	
5. SEX <u>Female</u>	6. COLOR OF RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 26 1906</u>
9. AGE (In years, last birthday) <u>54</u> yrs.		IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work one during most of working life, even if retired) <u>School Teacher</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WALTER HAINES</u>		14. MOTHER'S MAIDEN NAME <u>EMILY COALE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes, give year or dates of service) <u> </u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>WILLIAM E. McCOMAS</u>		Address <u>HAURE DE GRACE MD</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute pulmonary edema</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>acute cardiac failure</u> (c) <u>Carcinomatosis</u> DUE TO cause last.			
INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>4 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>May 1</u> 19 <u>61</u> to <u>May 2</u> 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>May 2</u> 19 <u>61</u> , and that death occurred at <u>12:30</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward J. Simon</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 5-2-61	
22c. PHYSICIAN'S NAME (Type) <u>EDWARD J. SIMON</u>		22d. ADDRESS <u>HAURE DE GRACE, MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>MAY 5, 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MOUNTAIN CHRISTIAN CH. 40.</u>		23d. LOCATION (City, town or county) (State) <u>HARFORD CO. MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>R. Madison Mitchell</u> ADDRESS <u>Harford Grace, Md.</u>		25. REC'D BY REGISTRAR <u>MAY 4 '61</u> DATE	
25a. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>		25b. REGISTRAR'S SIGNATURE	

M

I

William E. Corns have decided the
Emily Corals

1
FOR STATE
HEALTH DEPT.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Items 8 & 9 Film G287 5/22/61 mh

05669

1. PLACE OF DEATH e. COUNTY <i>Harford</i>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <i>md</i> b. COUNTY <i>Harford</i>		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Harford</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Aberdeen</i>		
c. LENGTH OF STAY in lb <i>10 days</i>			d. STREET ADDRESS <i>60 E Bel Air Ave</i>		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Harford Memorial Hospital</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <i>Evans M M, Tchell</i>			4. DATE OF DEATH <i>May 7 1961</i>		
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Dec. 29, 1914</i>		9. AGE (In years last birthday) <i>46</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Canner-Farmer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Cannery & Farm</i>	11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>
13. FATHER'S NAME <i>Malcolm Mitchell</i>			14. MOTHER'S MAIDEN NAME <i>Eva Osborn</i>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-32-1619</i>	17. INFORMANT <i>Lillian B. Mitchell, 60 E. Bel Air Ave, Aberdeen, Md.</i>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>1st, 2nd, + 3rd degree burns</i> DUE TO (b) <i>chest + upper extremities</i> DUE TO (c) <i></i>					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Toxic carbide fire</i>			
20c. TIME OF INJURY Month, Day, Year Hour e.m. <i>4-27</i> 19 <i>61</i> p.m. <i></i>	20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Aberdeen Harford md</i>	20f. (City or town) <i>Aberdeen</i>	(County) <i>Harford</i>	(State) <i>md</i>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Gerald C Palmer</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <i>5-8-61</i>	
EXAMINER'S NAME (Type) <i>Gerald C Palmer M.D.</i>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
Address (Street, city, town, or county) <i>Bel Air, md.</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>May 10, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Grove Cemetery</i>	22d. LOCATION (City, town, or country) (State) <i>Aberdeen, Maryland</i>		
23. FUNERAL DIRECTOR <i>John G. Tarring - Tarring Funeral Home</i>			24a. REC'D BY REGISTRAR <i>MAY 12 '61</i>		
ADDRESS <i>Aberdeen, Md.</i>			24b. REGISTRAR'S SIGNATURE <i>Charles S. Fries</i>		

TO THE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

THE STATE
OF NEW YORK

(M)

(1)

1900

DECLARATION OF DEATH

STATE OF NEW YORK

COUNTY OF []

TOWNSHIP OF []

WE, the undersigned, being the persons authorized by law to make such declaration, do hereby certify that []

was born on [] at []

and died on [] at []

of []

caused by []

and that the death was not caused by any contagious, infectious or violent disease.

Witness my hand and seal this [] day of [] 19[]

Attest: []

Notary Public for the State of New York

1
FOR STATE
HEALTH DEPT.

is necessary, if any, to the funeral director, Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

3681
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
05670

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hamden</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>	
c. LENGTH OF STAY IN lb <u>13 days</u>		d. STREET ADDRESS <u>136 Park Street</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>B</u> Last <u>Mitchell</u>		4. DATE OF DEATH Month <u>May</u> Day <u>3</u> Year <u>1961</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-72</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE (In years last birthday) <u>88</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Josiah Bell</u>		14. MOTHER'S MAIDEN NAME <u>Cornelia Mitchell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>(If yes give number or date of service)</u>	
17. INFORMANT <u>Mary F. Kaiser, 4212 Harcourt Rd.</u>		Address <u>Balto. 14, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of femur</u> 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Coronary occlusion. Pericarditis</u>			INTERVAL BETWEEN ONSET AND DEATH
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell in her home</u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>4-17</u> 19 <u>61</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State) <u>md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>B. A. King</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <u>5-3-61</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5/6/61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Grove Presbyterian Cemetery, Aberdeen, Md.</u>	22d. LOCATION (City, town, or country) (State)
23. FUNERAL DIRECTOR <u>John B. Tarring</u> ADDRESS <u>Tarring Funeral Home, Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 8 '61</u> DATE	24b. REGISTRAR'S SIGNATURE <u>Arthur L. King</u>

MEDICAL CERTIFICATION

2
12
2
bp



4 copies

Handwritten notes and signatures, including "Handwritten" and "130 Park Street".

Handwritten notes, including "Mary B. Mitchell" and "May 3 1911".

10-2-12 28

Handwritten notes, including "Dorothy Mitchell" and "Local Hall".

Handwritten notes, including "Mary B. Mitchell" and "May 3 1911".

Handwritten signature or name.

Handwritten notes, including "Handwritten" and "Fall in the morning".

Handwritten notes, including "Handwritten" and "May 3 1911".

Handwritten notes, including "Handwritten" and "May 3 1911".

Handwritten notes, including "Handwritten" and "May 3 1911".

Handwritten notes, including "Handwritten" and "May 3 1911".

Handwritten notes, including "Handwritten" and "May 3 1911".

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5682

CERTIFICATE OF DEATH

65671

1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Havre de Grace c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Harford Memorial Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen, d. STREET ADDRESS Chesapeake Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) CHARLES E. OLIVER		4. DATE OF DEATH Month May Day 12 Year 61		5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 4, 1875		9. AGE (In years last birthday) 85 yrs. IF UNDER 1 YEAR: Months 8 Days 19 Hours 61 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farm				11. BIRTHPLACE (County & State, or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James William Oliver						14. MOTHER'S MAIDEN NAME Sarah McCoy							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. *** **				17. INFORMANT Address Aberdeen, Md. Mrs. C.E. Oliver, Chesapeake Rd.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular accident 443X DUE TO (b) Arterio-sclerotic Cardio-vascular Disease Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. with Hypertension PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)													
21. I certify that (I) (this hospital) attended the deceased from Sept 12, 1961 to May 12, 1961 , that (I) (we) last saw the deceased alive on May 12, 1961 , and that death occurred at 5:15 PM M, from the causes and on the date stated above.													
22a. SIGNATURE J. Ralph Horky						22b. DATE SIGNED May 12, 1961							
22c. PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.						22d. ADDRESS Churchville, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF May 15, 1961				23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery				23d. LOCATION (City, town or county) (State) Perryman, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring John G. Tarring						25a. REC'D BY REGISTRAR MAY 16 '61						25b. REGISTRAR'S SIGNATURE Arthur S. Hanna	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

3232

Mar 27

Maryland

Harford

Laurel de Grace

Aberdeen

Harford Memorial Hospital

Chesapeake Road

CHARLES

OLIVER

May

12, 1901

Wife

June 4, 1875

Former

son

Maryland

U.S.A.

James William Oliver

Sarah McCoy

Aberdeen, Md.

No

as in

Mrs. C.E. Oliver, Chesapeake Rd.

Handwritten notes and signatures, including "C.E. Oliver" and "Sarah McCoy".

Handwritten notes and signatures at the bottom of the page, including "John A. Tarrill" and "Funeral Home".

1
FOR STATE
HEALTH DEPT.

TO DEPARTMENT OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the following is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. (Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.)
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

3683
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
05672

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>street</u>		c. LENGTH OF STAY in 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>street</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>R.D.</u>				d. STREET ADDRESS <u>R.D.</u>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Regina B. Rice</u>				4. DATE OF DEATH <u>May 11 1961</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-23-61</u>	9. AGE (In years last birthday) <u>3</u> yrs.	IF UNDER 1 YEAR Months <u>3</u> Days <u>3</u>	IF UNDER 24 HRS. Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>HANREGE GRACE, MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANCIS RICE</u>				14. MOTHER'S MAIDEN NAME <u>BETTY STEHLY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>FRANCIS RICE</u> , Address <u>STREET, MD.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> <u>491X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>—</u> DUE TO (c) <u>—</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>5-11-61</u> DATE SIGNED			
EXAMINER'S NAME (Type) <u>Gerald C Palmer, MD.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <u>Bel Air, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>5-13-61</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SLATE RIDGE</u>		22d. LOCATION (City, town, or country) <u>DELTA, PA.</u> (State)			
23. FUNERAL DIRECTOR <u>John H. Harkins, Delta, Penna.</u> ADDRESS				24a. REC'D BY REGISTRAR <u>MAY 12 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>	

FOR STATE
DEATH CERTIFICATE

141

1

MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: *FRANK RICE*

2. SEX: *Male*

3. AGE: *45*

4. DATE OF DEATH: *1951-10-15*

5. TIME OF DEATH: *10:30 AM*

6. PLACE OF DEATH: *Home*

7. CAUSE OF DEATH: *Heart Disease*

8. MANNER OF DEATH: *Natural*

9. SIGNATURE OF MEDICAL EXAMINER: *Dr. J. H. Smith*

10. SIGNATURE OF REGISTRAR: *J. H. Smith*

11. SIGNATURE OF CLERK: *J. H. Smith*

12. SIGNATURE OF WITNESSES: *J. H. Smith*

13. SIGNATURE OF FUNERAL HOME: *J. H. Smith*

14. SIGNATURE OF CHURCH: *J. H. Smith*

15. SIGNATURE OF OTHER: *J. H. Smith*

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 05673

5684

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Cheseeen</i>		c. LENGTH OF STAY IN 1b <i>1958</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>610 New Street</i>		e. STREET ADDRESS <i>610 New Street</i>	
3. NAME OF DECEASED (Type or print) First <i>Wizwise</i> Middle <i>Beatrice</i> Last <i>Richards</i>		4. DATE OF DEATH Month <i>5</i> Day <i>11</i> Year <i>1961</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/29/1880</i>
9. AGE (In years last birthday) <i>81</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Nova Scotia</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Herman Heary</i>		14. MOTHER'S MAIDEN NAME <i>Mary Jane (unknown)</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>032-10-5785</i>	
17. INFORMANT <i>Wm Irving F. Hill - 610 New St. Cheseeen</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i> <i>332</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>arteriosclerotic Cerebrovascular disease</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>4 days</i> <i>> 5 yrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <i>19</i> a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-7-61</i> , 19 <i>61</i> , to <i>5-11-61</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>5-7-61</i> , 19 <i>61</i> , and that death occurred at <i>10 P</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>B J Plunkett Jr</i> M.D.		ADDRESS (Street, city or town, state) <i>617 W. Bel Air Ave.</i>	
PHYSICIAN'S NAME (Type) <i>B.J. Plunkett Jr., M.D.</i>		DATE SIGNED <i>5-12-61</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF <i>5/12/61</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Cherry Valley Cemetery</i>	22d. LOCATION (City, town, or county) (State) <i>Cherry Valley Mass.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Totum E. Tarning - Aberdeen, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>MAY 16 '61</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL HOME OR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1986

2000-0000-0000

<p>1. NAME OF DECEASED [Illegible]</p>		<p>2. SEX [Illegible]</p>	
<p>3. AGE [Illegible]</p>		<p>4. DATE OF BIRTH [Illegible]</p>	
<p>5. PLACE OF BIRTH [Illegible]</p>		<p>6. DATE OF DEATH [Illegible]</p>	
<p>7. CAUSE OF DEATH [Illegible]</p>		<p>8. MANNER OF DEATH [Illegible]</p>	
<p>9. SIGNATURE OF PHYSICIAN [Illegible]</p>		<p>10. SIGNATURE OF REGISTRAR [Illegible]</p>	
<p>11. SIGNATURE OF WITNESS [Illegible]</p>		<p>12. SIGNATURE OF DECEASED [Illegible]</p>	
<p>13. SIGNATURE OF NEXT OF KIN [Illegible]</p>		<p>14. SIGNATURE OF BURIAL SOCIETY [Illegible]</p>	
<p>15. SIGNATURE OF FUNERAL HOME [Illegible]</p>		<p>16. SIGNATURE OF CHURCH [Illegible]</p>	
<p>17. SIGNATURE OF CEMETERY [Illegible]</p>		<p>18. SIGNATURE OF OTHER [Illegible]</p>	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5685

CERTIFICATE OF DEATH

05674

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u> c. LENGTH OF STAY IN 1b <u>1 1/2 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>HARFORD Memorial Hosp</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>PERRYMAN</u> d. STREET ADDRESS <u>1</u>					
3. NAME OF DECEASED (Type or print) <u>HAZEL</u> A. <u>RICKETTS</u> First Middle Last				4. DATE OF DEATH Month <u>MAY</u> Day <u>7</u> Year <u>1961</u>					
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 12, 1894</u>		9. AGE (In years, last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>C. Arlie Aaronson</u>				14. MOTHER'S MAIDEN NAME <u>Pearl Mallock</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>** ** *</u>		17. INFORMANT <u>Clifford Ricketts, Perryman, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>260X</u> DUE TO <u>Acidosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Anuria</u> DUE TO (c) <u>Diabetes Mellitus (Kimmelstiel-Wilson Syndrome)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Generalized arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH: <u>2 days</u> <u>2 days</u> <u>6 months</u>									
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Hour _____ e.m. _____ p.m. _____ Month, Day, Year _____ 19____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>1948</u> to <u>5-7-61</u> , that (I) (we) last saw the deceased alive on <u>5-6-61</u> , and that death occurred at <u>1:15 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Peter P. Rodman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-8-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>				22d. ADDRESS <u>8 Law St., Aberdeen, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 9, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Spesutia Cemetery</u>		23d. LOCATION (City, town or county) _____ (State) _____ <u>Perryman, Maryland</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Farrelly</u>				Tarring Funeral Home <u>Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u>MAY 12 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed in 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

1883

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I

Home
Homeside
C. Aris Johnson

William Johnson
Homeside, Maryland
C. Aris Johnson

1883

Archie

Archie (known to William Johnson)

Robert P. Johnson, M.D., 8 New St., Aberdeen, Md.

Robert P. Johnson, M.D., 8 New St., Aberdeen, Md.

Robert P. Johnson, M.D., 8 New St., Aberdeen, Md.
Turning Point Home
Aberdeen, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

3686

05675

1. PLACE OF DEATH a. COUNTY HARFORD b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HARFORD c. LENGTH OF STAY IN 1b 16 1/2 hrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HARFORD MEMORIAL HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEL AIR d. STREET ADDRESS Box 309 R.D 3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CHARLES Middle RINEHART Last RINEHART		4. DATE OF DEATH Month MAY Day 22 Year 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-61
9. AGE (In years last birthday) yrs. 16		IF UNDER 1 YEAR Months 10 Days 18	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) HARFORD Co. MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES RINEHART		14. MOTHER'S MAIDEN NAME EVELYN LEONARD	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMATION Mr. Charles Rinehart, Bel Air Rural, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ANENCEPHALUS - 750X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) — DUE TO (c) —		INTERVAL BETWEEN ONSET AND DEATH 15 HOURS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) —			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from MAY 21 , 1961, to MAY 21 , 1961, that (I) (we) last saw the deceased alive on MAY 21 , 1961, and that death occurred 6:25 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Philip W. Heuman M.D.		22b. DATE SIGNED MAY 22, 1961	
22c. PHYSICIAN'S NAME (Type) PHILIP W. HEUMAN M.D.		22d. ADDRESS 307 HICKORY, BEL AIR, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF MAY 23, 1961	
23c. NAME OF CEMETERY OR CREMATORY St. Ignatius Cemetery		23d. LOCATION (City, town or county) (State) Hickory, Harford Co., Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St. Bel Air, Maryland		25a. REC'D BY REGISTRAR MAY 24 '61 DATE	
25b. REGISTRAR'S SIGNATURE Arthur L. Kraus			

VR A15 (4)
15M 9/60

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TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
5687 CERTIFICATE OF DEATH 05676											
1. PLACE OF DEATH a. COUNTY Harford MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Aberdeen,						c. LENGTH OF STAY IN 1b 28 Aberdeen					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 634 Colaine Drive						d. STREET ADDRESS 634 Colaine Drive					
3. NAME OF DECEASED (Type or print) JOSEPH						4. DATE OF DEATH Month May Day 31 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH March 15, 1890		9. AGE (in years last birthday) 71 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber, (Ret.)				10b. KIND OF BUSINESS OR INDUSTRY Barber		11. BIRTHPLACE (County & State, or foreign country) Italy				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Unknown						14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 057-28-9110					
17. INFORMANT Mary Phillips, 634 Colaine Drive, Aberdeen, Maryland											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Abdominal Circumcision 199X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While et work <input type="checkbox"/> Not While et work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from 4-12-61 to 5-31-1961 , that (I) (we) last saw the deceased alive on 5-31-1961 , and that death occurred at 7:45 PM from the causes and on the date stated above. 22a. SIGNATURE B.J. Plunkett Jr. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22c. PHYSICIAN'S NAME (Type) B.J. Plunkett Jr. M.D. 22d. ADDRESS 617 W. Bel Air Ave., Aberdeen, Md. 22b. DATE SIGNED 6-1-61 23a. BURIAL, CREMATION, REMOVAL (Specify) Removal 23b. DATE THEREOF 6/1/61 23c. NAME OF CEMETERY OR CREMATORY St. Peters Cemetery 23d. LOCATION (City, town or county) (State) Poughkeepsie, New York 24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring - Tarring Funeral Home 25a. REC'D BY REGISTRAR JUN 5 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Hays											

(M)

Hartford

Abingdon

Abingdon

Abingdon Drive

Abingdon Drive

1934

1934

1934

Wife

Wife

Abingdon (1934)

Abingdon (1934)

U.S.A.

Unknown

Unknown

Abingdon Drive

Abingdon, Maryland

Abingdon Drive

1934

1934

Abingdon

X

Abingdon, Md.

Abingdon

Abingdon

Abingdon

Abingdon

Abingdon

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5688

CERTIFICATE OF DEATH

05677

1. PLACE OF DEATH a. COUNTY Harford MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Street c. LENGTH OF STAY IN 1b 61 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Harford c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural - Street d. STREET ADDRESS Grier Nursery Rd. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last EDWARD W. STEWART				4. DATE OF DEATH Month Day Year May 2, 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 31, 1899		9. AGE (In years last birthday) 61 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Auto mechanic				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Street, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James W. Stewart				14. MOTHER'S MAIDEN NAME Lillis D. Iley					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 214-22-3099		17. INFORMANT Address Mrs. Edward W. Stewart, Street, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526X DUE TO for pulmonary embolism, complications, complete Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 12/20/57 DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 20g. (City or town) (County) (State) 20h. (City or town) (County) (State)								INTERVAL BETWEEN ONSET AND DEATH 12/20/57	
21. I certify that (I) (this hospital) attended the deceased from May 1, 19 61, to May 2, 19 61, that (I) (we) last saw the deceased alive on May 1, 19 61, and that death occurred at 2:00 P.M. from the causes and on the date stated above.								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
22a. SIGNATURE Benj. Dorogi				22b. DATE SIGNED 5-5-61		22c. PHYSICIAN'S NAME (Type) Benj. Dorogi			
22d. ADDRESS Cardiff, Maryland				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF May 5, 1961		23c. NAME OF CEMETERY OR CREMATORY Highland		23d. LOCATION (City, town or county) (State) Street, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE John H. Haskins				24a. ADDRESS Delta, Pa.		25a. REC'D BY REGISTRAR MAY 8 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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1227

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely lined in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 4
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5688

05678

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>27 Havre de Grace</u>	
c. LENGTH OF STAY IN lb <u>10 days</u>		d. STREET ADDRESS <u>1418 N Stokes St.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hosp.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Earle</u> Middle <u>M</u> Last <u>Stirling</u>		4. DATE OF DEATH Month <u>May</u> Day <u>18</u> Year <u>1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 31 - 1890</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Construction</u>	11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Albert Stirling</u>	
14. MOTHER'S MAIDEN NAME <u>Hannah (Smith) Stirling</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>	
16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Chas P. Stirling</u> Address <u>418 N. Stokes St. Md</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE <u>Bronchopneumonia, left upper lobe</u> (b) DUE TO <u>491X</u> (c) DUE TO <u>491X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pulmonary tuberculosis with cavities, left</u> INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>002X</u>		20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>	
20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>002X</u>	
20f. (City or town) <u>002X</u>		20g. (County) <u>002X</u>	
20h. (State) <u>002X</u>		21. I certify that (I) (this hospital) attended the deceased from <u>5/18/61</u> to <u>5/18/61</u> , that (I) <u>(was)</u> last saw the deceased alive on <u>5/18/61</u> , and that death occurred at <u>10 AM</u> , from the causes and on the date stated above.	
22a. SIGNATURE <u>Edward C. Loo</u>		22b. DATE <u>5/19/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		22d. ADDRESS <u>Havre de Grace, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>5/21/61</u>		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY <u>Garfield Hill</u>		23d. LOCATION (City, town or county) <u>Harford Co. Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Donna L. Loo</u>		25a. REC'D BY REGISTRAR <u>DATE MAY 23 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Loo</u>		25c. REGISTRAR'S SIGNATURE	

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2082

DEPARTMENT OF DEATH

10822

There is a grave in the
Cemetery of the
City of New York
containing the remains
of a person who died
on the 10th day of
April 1882.
The person whose name
is on the monument
is a woman who died
on the 10th day of
April 1882.
The monument is made
of marble and is in
the shape of a cross.
The name of the person
is on the front of the
cross.

(S)

The monument is made
of marble and is in
the shape of a cross.
The name of the person
is on the front of the
cross.
The person whose name
is on the monument
is a woman who died
on the 10th day of
April 1882.
The monument is made
of marble and is in
the shape of a cross.
The name of the person
is on the front of the
cross.

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5690

CERTIFICATE OF DEATH

05679

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Havre de Grace</u>		c. LENGTH OF STAY in lb <u>8 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>XXXXXXXXXX Bel Air</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial</u>				d. STREET ADDRESS <u>Rt # 2 Box 164</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>John Franklin Supik</u>		First Middle Last		4. DATE OF DEATH <u>5 16 1961</u>		Day Month Year	
5. SEX <u>M</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 16, 1881</u>	
9. AGE (In years last birthday) <u>80</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer & Blacksmith</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm & Shop</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Albert Supik</u>				14. MOTHER'S MAIDEN NAME <u>Carrie Supik (Sdec)</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>215-22-6951</u>				16. SOCIAL SECURITY NO. <u>215-22-6951</u>			
17. INFORMANT <u>John F. Supik Jr., RD 2, Bel Air, Md.</u>				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure & Arterio-sclerotic Heart Disease</u> <u>527.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pulmonary Edema</u> DUE TO (c) <u>Chronic Lung Disease (Emphysema)</u>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Acute Suppurative Cholecystitis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/16/61</u> to <u>5-16, 1961</u> ; that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>5:30</u> P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank D. Hauber</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>5-17-61</u>	
22c. PHYSICIAN'S NAME (Type) <u>Frank D. Hauber, M.D.</u>				22d. ADDRESS <u>610 S. Union Ave, Havre de Grace, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>May 19, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Bel Air Memorial Gardens</u>		23d. LOCATION (City, town or county) (State) <u>Bel Air, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>				Tarring Funeral Home Aberdeen, Md.		25a. REC'D BY REGISTRAR DATE <u>MAY 22 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>			

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May 19, 1961

Form 1 Shop

515-22-0021 John E. Dupik Jr., 501 Air, Md.

Frank E. Huber, M.D., 515 S. Union Ave., State of Md.

May 19, 1961, 501 Air Memorial Gardens, 501 Air, Md.

Turning Funeral Home

Aberdeen, Md.

John E. Dupik

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

5691

CERTIFICATE OF DEATH

056811

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> c. LENGTH OF STAY IN lb <u>6 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> d. STREET ADDRESS <u>Chapel Terrace</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Louise Thompson</u>		4. DATE OF DEATH Month <u>May</u> Day <u>24</u> Year <u>1961</u>		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>May 4, 1895</u> 9. AGE (In years last birthday) <u>66</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Hohn Yeager</u> 14. MOTHER'S MAIDEN NAME <u>Ida (Shanell) Yeager</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u> </u> (If yes give war or dates of service) <u> </u> 16. SOCIAL SECURITY NO. <u> </u> 17. INFORMANT <u> </u> Address <u> </u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>1- Bronchopneumonia</u> 491X } DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (c) <u>2- A.S.C.V.D. and H.C.V.D.</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Diabetes Mellitus & Chronic Cholecystitis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>7 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u>Harre de Grace</u> (County) <u>Harford</u> (State) <u>Md.</u>			
21. I certify that (I) (this hospital) attended the deceased from <u>May 19th 1961</u> to <u>May 24th 1961</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>May 24th 1961</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Edward C. Loo, M.D.</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				22b. ADDRESS <u>Harre de Grace, Md.</u> 22d. ADDRESS <u> </u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>5/28/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Calvary Cemetery</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Tarring</u>		24b. ADDRESS <u>Tarring Funeral Home</u> <u>Aberdeen, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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May 11, 1882

Home

Hotel 2/28/81
Tarting General Home
Aberdeen, Md.
R.D. Bel Air, Maryland
Calvary Cemetery

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

5692

CERTIFICATE OF DEATH

Reg. Dist. No. 5681

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Magnolia				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Clinton Middle Alexander Last Turner				4. DATE OF DEATH Month May Day 3 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 27, 1894	
9. AGE (In years last birthday) yrs. 66		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Locomotive Operator				10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov.		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME John Turner				14. MOTHER'S MAIDEN NAME Alice Stauffer			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-20-7020		17. INFORMANT Address Mrs. Clinton Turner Magnolia, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Gastrointestinal Hemorrhage. 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Myocardial Infarction DUE TO (c) Myocardial Infarction							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour 0. 11. p. m. 19				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 4/26 , 19 61 , to 5/3 , 19 61 , that I last saw the deceased alive on 4/26 , 19 61 , and that death occurred at 11 A M, from the causes and on the date stated above.							
ACTUAL SIGNATURE E. Louis Kahan M.D.				ADDRESS (Street, city or town, state) Box 966 Edgewood DATE SIGNED 5/3/61			
PHYSICIAN'S NAME (Type) E. Louis Kahan				Edgewood, Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF May 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Cokesbury Memorial		22d. LOCATION (City, town, or county) (State) Abingdon, Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Howard K. McComas & Son				ADDRESS Abingdon, Md.		24a. REC'D BY REGISTRAR DATE MAY 8 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. Knead			

entirely!

2. Louis Kahn

М. В. Ломоносов, 1751 г.

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FOR STATE
HEALTH DEPT.
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Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
5693 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05682

1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u> c. LENGTH OF STAY IN 1b <u>Post</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DOA Harford Memorial Hospital</u>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Cecil</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rising Sun Rural</u> d. STREET ADDRESS <u>07X-2</u>		
3. NAME OF DECEASED (Type or print) <u>Gregor yolen Wilson</u>			4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>1961</u>		
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-16-1915</u>	9. AGE (In years last birthday) <u>45</u> yrs.	IF UNDER 1 YEAR Months <u>4</u> Days <u>5</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Painter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Const. Co.</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
13. FATHER'S NAME <u>Abe Wilson</u>			14. MOTHER'S MAIDEN NAME <u>Bine Holcomb</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u>			16. SOCIAL SECURITY NO. <u>234 205 871</u>		
17. INFORMANT <u>Mrs. STELLA Wilson</u>			Address <u>Rising Sun, Md.</u>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>925X</u> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Crushing injury chest. Fracture R humerus</u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <u>Auto accident</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>am</u> <u>4</u> <u>5-12-61</u> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <u>Cecil</u>	(County) <u>Md</u>	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Gerald C Palmer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>BEA, Md.</u>		DATE SIGNED <u>5-12-61</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-16-1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Mingo Cem.</u>	22d. LOCATION (City, town, or country) <u>Mingo</u>	(State) <u>West Virgo</u>	
23. FUNERAL DIRECTOR <u>Tomon E McAllen</u>		ADDRESS <u>Rising Sun, Md.</u>		24a. REC'D BY REGISTRAR <u>MAY 16 '61</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>

TO DIE MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any, is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

